Shepherd of the Valley Preschool
Child Health Information Record
Physician to Complete Information

Child's Name: _____

Child's Birth Date: _____

Date of most recent well child check _____

Shepherd of the Valley Preschool must have a copy of the most current immunization record on file
(Please explain on back of form if immunization record is not current)

What, if any, significant health problems has this child had in the past? _____

_____

_____

Does this child have any of the following: ***(if yes, please describe)***

Allergies	☐ Yes ☐ No
Abnormal result on a hearing test	☐ Yes ☐ No
Abnormal result on a vision test	☐ Yes ☐ No
Recurring chronic illness/health problems	☐ Yes ☐ No
Disabilities (such as cerebral palsy, seizure disorder, developmental delay)	☐ Yes ☐ No

If you answered "yes," to any of the above, please explain and provide any follow-up measures or appointments:

_____

_____

_____

_____

What medications does this child take regularly? _____

_____

If this child has any special health care or food needs, please describe the individualized care plan or any special instructions:

_____

_____

_____

Physician Name (Printed) **Signature of Physician** **Date**

(Edited 3-2018)